

# NEW PATIENT INTAKE AND MEDICAL HISTORY FORM

## Instructions for completing this form:

1. This form must be completed in its entirety before an appointment for an evaluation can be scheduled.
2. Pictures of all insurances cards (front and back) need to be attached.
3. Send this form, copy of insurance cards, the Consent for Seating and Positioning Services form, and the Seating and Positioning Physician Referral form to the clinic in order to schedule an evaluation.

**IMPORTANT:** Is patient receiving Home Health Care for any reason? ☐ Yes ☐ No If yes, what company? \_\_\_\_\_

**PLEASE SELECT ONE:** ☐ DIDD Waiver ☐ ECF Waiver ☐ State ICF/IID ☐ Private ICF/IID ☐ Dept. Children's Services ☐ N/A

<b>REASON FOR REFERRAL</b>				
<b>PATIENT INFORMATION</b>				
Last Name:		First Name:		Middle Name:
				SS#: - -
Street Address:			City:	State: Zip:
Date Form Completed:		Date of Birth (mm-dd-yyyy):		Gender:
				<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>CONTACT INFORMATION</b>				
Contact Person Name (for scheduling):			Contact Person Phone:	Relationship to Patient:
Supporting Agency (if applicable):			Agency Phone:	
Independent Support Coordinator or Case Manager:				Phone:
<b>PHYSICIAN INFORMATION</b>				
Referring Physician Name:			Phone:	Fax:
Primary Care Physician (if different):			Phone:	Fax:
<b>PRIMARY INSURANCE INFORMATION</b>				
Name of Insurance Company:			ID Number:	Group Number:
Policy Holder Name:			Policy Holder Date of Birth:	Policy Holder SS#:
				- -
Insurance Company Phone Number:			Policy Holder Relation to Patient:	
			<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
<b>SECONDARY INSURANCE INFORMATION</b>				
Name of Insurance Company:			ID Number:	Group Number:
Policy Holder Name:			Policy Holder Date of Birth:	Policy Holder SS#:
				- -
Insurance Company Phone Number:			Policy Holder Relation to Patient:	
			<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	

<b>OTHER SERVICES</b>	
Is patient receiving any other therapy services? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, what type? <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SLP	
Therapist(s) contact information:	
<b>MEDICAL CONDITIONS</b>	
Please check if you have any of the following (or attach a list):	
<input type="checkbox"/> Arthritis <input type="checkbox"/> Aspiration pneumonia <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Constipation <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> Dysphagia <input type="checkbox"/> Gastroesophageal Reflux Disease	<input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Intellectual/developmental disability <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Osteoporosis/osteopenia <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polio/post-polio
<input type="checkbox"/> Recent falls <input type="checkbox"/> Recent fractures <input type="checkbox"/> Seizures <input type="checkbox"/> Spina bifida <input type="checkbox"/> Stroke <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
Please check any medical equipment you use:	
<input type="checkbox"/> Ceiling lift <input type="checkbox"/> CPAP/BiPAP machine <input type="checkbox"/> G-tube/J-tube/G-J tube	<input type="checkbox"/> Mechanical floor lift <input type="checkbox"/> Shower/bath chair or bench <input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Other: <input type="checkbox"/> Other:	
Do any of your medical issues interfere with your ability to complete your daily activities/routine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
<b>OTHER MEDICAL ISSUES</b>	
Have you had any hospitalizations in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Type(s) and Date(s):	Have you had any surgeries in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Type(s) and Date(s):
Please list any medications you are presently taking (or attach a list):	
Height:	Do you have a history of pressure injuries (skin breakdown)? If so, please explain:
Weight:	
<b>WHEELCHAIR AND POSITIONING EQUIPMENT INFORMATION</b>	
Please indicate equipment you <u>currently</u> have:	
<input type="checkbox"/> Bed positioning <input type="checkbox"/> Communication device <input type="checkbox"/> Custom Dining chair <input type="checkbox"/> Hospital bed	<input type="checkbox"/> Mobile bed positioning (CIS) <input type="checkbox"/> Prone on forearms <input type="checkbox"/> Quadraped on forearms <input type="checkbox"/> Recliner
<input type="checkbox"/> Sidelyer <input type="checkbox"/> Stander <input type="checkbox"/> Tall kneeler <input type="checkbox"/> Wheelchair, manual	
<input type="checkbox"/> Wheelchair, power <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
Does any of your equipment interfere with your ability to complete your daily activities/routine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	

**WHEELCHAIR AND POSITIONING EQUIPMENT INFORMATION (CONT'D)**

Do you have a current durable medical equipment (DME) vendor who provided you with and/or repairs your wheelchair or other equipment? ☐ Yes ☐ No If yes, what is the name of the company?

Would you like to continue to use the same vendor, if possible? ☐ Yes ☐ No

Can your wheelchair fit everywhere you need it to go?

☐ Yes ☐ No ☐ N/A (I do not have a wheelchair)

If no, please explain:

**OUTCOMES FOR APPOINTMENT**

What outcomes would you like to see as a result from this appointment?

**Form Completed By:**

**Contact number:**

**Date Completed:**

**CLINIC LOCATIONS AND CONTACT INFORMATION:**

**West TN Clinic**

**Phone: (901) 745-7509**

**Fax: (901) 745-7742**

[WTRC.Seating.Positioning@tn.gov](mailto:WTRC.Seating.Positioning@tn.gov)

**Middle TN Clinic**

**Phone: (615) 231-5147**

**Fax: (615) 886-9972**

[MTRC.Referrals@tn.gov](mailto:MTRC.Referrals@tn.gov)

**East TN Clinic**

**Phone: (423) 787-6689**

**Fax: (423) 798-6220**

[ETRC.Referrals@tn.gov](mailto:ETRC.Referrals@tn.gov)